Wyoming Department of Health

AGING DIVISION – DOCUMENT 07-01-2011
AGING NEEDS EVALUATION SUMMARY (AGNES)

Client Name_____

Site location:	Service provider:	Date:

Name: _____
FIRST MI LAST

Nickname, if any

Mailing Address:

City State Zip Code

Street Address:

City State Zip Code

Birth date _____ _____ Female _____ Male

Telephone Number(s)
Home cell or message
(_____)_____-_____ (_____)_____-_____

In the past year, have you received services from more than one Senior Center in Wyoming? _____NO _____ YES

- If yes, where: _____
- Did you complete this form and sign a Release at that site? _____ NO _____ YES

Do you have difficulty reading or writing? _____ NO____YES
Do you require an interpreter or reader? _____NO____YES

Emergency Contact Information

Name of Emergency Contact Person

Mailing Address

City

State ZIP code

Telephone number(s)

Relationship to you, if any_____

Do you live in a rural area ? _____ NO _____ YES

(Answer NO, if you live in Casper, Cheyenne, Gillette, Laramie, or Rock Springs. All other areas of state should be marked rural)

Language spoken
_____ English _____ Spanish
_____ Russian _____ Other
_____ Native American _____ Asian
Please list other: _____

Marital Status
_____ Single/Widowed _____ Married
Spouse Name _____
Spouse Birth date _____

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Commit to your health.

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Do you live alone ___NO ___YES	Are you a veteran? _____ NO _____ YES (served active duty and honorably discharged) Are you a spouse or dependant of a veteran? _____ NO _____ YES
Race ___White ___ Black/African American ___ Asian, Specify nationality_____ ___ Native American____ Pacific Islander ___ Other, please list_____	Ethnicity ___ Hispanic/Latino Other, please specify: _____ Do you have a heart condition? ___ NO ___ YES Do you have diabetes? ___ NO ___YES
Are you a caregiver_____No _____Yes Is the person you give care to: (a) over 60 (b) have Alzheimer's or Dementia (c) an adult with disabilities or (d) a minor child 18 or younger _____No _____Yes Person you care for:_____ Address_____ Phone Number _____ Date of Birth _____ Gender ___Female ____Male Relationship to You _____	Have you ever had a pneumonia shot? ____NO ____YES Have a flu shot this year? ____NO ____YES Have you received information about the shingles vaccine? ____NO ____YES Is your family gross annual income at or below this amount _____ NO _____ YES **FAMILY SIZE 1 - $10,890 FAMILY SIZE 3 - $18,530** **FAMILY SIZE 2 - $14,710 FAMILY SIZE 4 - $22,350**

*Nutritional Risk Assessment (Please **Circle** Yes or No)*

I have an Illness or condition that changes the kind or amount of food I eat.	$Yes_{(2)}$	$No_{(0)}$
I eat fewer that two (2) meals per day.	$Yes_{(3)}$	$No_{(0)}$
I eat fewer than 5 servings (1/2 cup each) of fruits or vegetables daily.	$Yes_{(1)}$	$No_{(0)}$
I eat/drink fewer than two servings of dairy (milk/cheese) products daily.	$Yes_{(1)}$	$No_{(0)}$
I have 3 or more drinks of beers, wine or hard liquor every day.	$Yes_{(2)}$	$No_{(0)}$
I have tooth, mouth or swallowing problems that make it difficult to eat.	$Yes_{(2)}$	$No_{(0)}$
I eat alone most of the time.	$Yes_{(1)}$	$No_{(0)}$
I take 3 or more different prescribed or over-the-counter medications daily.	$Yes_{(1)}$	$No_{(0)}$
I am not always able to shop, cook and/or feed myself.	$Yes_{(2)}$	$No_{(0)}$
I have unintentionally lost or gained 10 pounds in the past 6 months.	$Yes_{(2)}$	$No_{(0)}$
Sometimes, I do not have enough money to buy food.	$Yes_{(4)}$	$No_{(0)}$
Nutritional Risk Score:		_____

High Risk – 6 or more points Moderate Risk - 3-5 points Low Risk – 0-2 points

Type of evaluation: **Initial evaluation:** B/C1/ D; C2/Care Receiver/CBIHS/ B (IHS)
Re-evaluation: B/C1/ D; C2/Care Receiver/CBIHS/ B (IHS)

PERSON REVIEWING FORM: _____

RELEASE OF INFORMATION

I hereby give my permission for _____ [SERVICE PROVIDER] to share information contained in the AGING NEEDS EVALUATION SUMMARY and other program documentation with the Aging Division and other affiliated service providers for the purpose of eligibility for the Administration on Aging and State of Wyoming **grant programs** such as supportive services, congregate meals, home-delivered meals, preventive services, community in-home services, family caregiver services.

Further, I understand that: By agreeing to take part in this program I give my permission to the service provider(s), Wyoming Department of Health (WDH), Aging Division, and the Administration on Aging (AoA) to share information obtained for the purpose of program evaluation and oversight.

Information received will be treated as **confidential** and will only be made available in accordance with the requirements of law.

I may cancel this release at any time except to the extent that action has been taken in reliance on it, and that in any event this release expires automatically one year from the date of my signature.

If I do not sign this release for the purposes described above, I may be required to pay for any services I have received or be solely responsible for payment of services.

If I am denied program services, I may be entitled to a hearing.

I have the right review and/or obtain a copy of my record including an accounting of any disclosures made from my record.

If I feel information in my record is invalid, I may make a written request for an amendment of the record. I have been provided a copy of this form.

If I feel I have been treated inappropriately, services have not been of the quality expected and/or not provided as stated in the service plan; I may contact the Wyoming Long Term Care Ombudsman at **(800)-856-4398)** or the WDH Aging Division at **(800) 442-2766.** For additional information regarding the Wyoming Department of Health's privacy policy, visit the WDH Department's HIPAA website: http://www.health.wyo.gov/main/hipaa.html or call De Anna Greene, WDH HIPAA Compliance Officer at **(307) 777-8664**.

Client or Representative's Signature: _____

Date: _____

Authority and Relationship of Representative (if any) to sign on Client's behalf

_____

Witness: _____ **Date:** _____

Nutritional Risk Score	-Nutrition Risk Action
0-2 Low Risk	- Recheck in 12 months
3-5 Moderate Risk	- Recheck in 3-6 months, Provide "Eating Well as We Age Brochure" or similar information.
6 or more High Risk	- Recommend to client that he or she discuss their nutritional risk score with their health professional or dietitian. Client is at high nutritional risk.

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Client Name_____

Activities of Daily Living (ADL's)

Rate client's ability to perform BATHING. (Include shower, full tub or sponge bath, exclude washing back or hair.)

- 0 Independent
- 2 Intermittent supervision or minimal physical assistance (stand by assistance)
- 4 Partial assistance (can perform some but not all of the bathing activity)
- 6 Total dependence

Rate client's ability to EAT.

- 0 Independent
- 2 Limited assistance (need assistive devices or minimal physical assistance)
- 4 Extensive help (client needs continuous cueing, assistance or supervision)
- 6 Total dependence

Rate client's ability to perform DRESSING.

- 0 Independent
- 1 Limited physical assistance (help with zippers, buttons and adjusting clothing)
- 2 Reminding, cueing or monitoring
- 3 Extensive assistance
- 4 Total dependence

Rate client's ability to perform TOILETING.

- 0 Independent
- 2 Reminding, cueing or monitoring
- 4 Limited physical assistance (help adjusting clothing or incontinence supplies)
- 6 Extensive assistance (wiping, cleaning or changing)
- 8 Total dependence

Rate client's ability to perform TRANSFER.

- 0 Independent
- 1 Limited physical assistance (includes assistive devices, i.e. walkers and canes)
- 2 Extensive assistance (care provider uses assistive devices, gait belt, etc)
- 3 Total dependence

Rate client's mobility IN HOME.

- 0 Independent
- 1 Limited Physical Assistance (includes assistive devices, walkers and canes)
- 2 Extensive Assistance (includes assistive devices, gait belt, wheelchair)
- 3 Total dependence

Instrumental Activities of Daily Living (IADL's)

Rate client's ability to PREPARE MEALS

- 0 Independent OR Prepares simple or partial meals (frozen, ready-made food, cereal, sandwich)
- 1 Prepares with verbal cueing or reminding
- 2 Prepares with minimal help (cut, open or set up)
- 3 Does not prepare any meals

Rate client's ability to perform SHOPPING.

- 0 Independent
- 2 Does with supervision, verbal cueing or reminders
- 4 Shops with hands-on help or assistive devices
- 6 Done by others or shops by phone

Rate client's ability to MANAGE MEDICATIONS.

- 0 Independent
- 2 Done with help some of the time
- 4 Done with help all of the time

Rate client's ability to MANAGE MONEY.

- 0 Completely independent
- 2 Needs assistance sometimes
- 4 Needs assistance most of the time
- 6 Completely dependent

Rate client's ability to USE THE TELEPHONE.

- 0 Independent
- 1 Can perform with some human help
- 2 Cannot perform function at all without human help

Rate client's ability to perform HEAVY HOUSEWORK.

- 0 Independent
- 1 Needs assistance sometimes
- 2 Does with maximum help
- 3 Unable to perform tasks

Rate client's ability to perform LIGHT HOUSEKEEPING.

- 0 Independent
- 1 Needs assistance sometimes
- 2 Needs assistance most of the time
- 3 Unable to perform tasks

Rate client's ability to access TRANSPORTATION.

- 0 Independent
- 1 Done with help some of the time
- 2 Done by others
- 3 Requires ambulance

Quarter period_____.

ADL TOTAL NUMBER_____

ADL TOTAL SCORE_____

Client Initial_____.

Date_____.

IADL TOTAL NUMBER_____

IADL TOTAL SCORE_____

ACC Initial_____.

No	Yes	CBIHS INFORMATION HOME VISIT EVALUATION
		Safe access to all necessary areas of home?
		Electrical hazards in home?
		Dangers on stairs or floors
		Cluttered/soiled living area
		Inadequate sewage disposal
		Inadequate/improper food storage
		Insects/rodents present
		Indoor toileting facilities
		Does client have trash removal service
		Outdoor toileting
		Problems with locks on doors and windows
		Hard to get in and out of bathroom
		Do kitchen appliances work properly
		Problems with water/hot water/plumbing issues
		Home temperature able to be controlled
		Functioning clothes washer
		Functioning clothes dryer
		Functioning telephone/cell phone
		Outside steps and walkways in good repair
		Does person feel safe in the neighborhood
		Pets in home
		Adequate food for pets
		Is client able to exit safely in an emergency
		Does client need assistance to exit in an emergency
		Fire hazards in home (frayed cords, items next to heater)
		Smoke detectors installed in home (need batteries?)
		Carbon monoxide detectors in home (need batteries?)
		Free from odors and pests
		Other hazards noted:

Comments or Notes:
Directions to the clients home for services for home services?
SPECIAL DIET:

ELIGIBILITY CHECKLIST

No	Yes	Check all answers that apply: Home bound, eligibility for Home delivered meals, CBIHS or other in home services (Title III B)
		Person homebound because of geographical isolation (outside the boundaries of public transportation service area.)
		Homebound on recommendation of medical practitioner.
		Homebound due to frail health, illness or disability.
		Homebound due to mental or social limitations or isolation.
		Homebound - other reason, list
		ADL (number 2 or more)
		IADL (number 2 or more)
		Other reasons: List